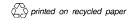
This form may be completed online, printed and mailed to the address listed.

Nebraska Health and Human Services System



	PARENTS: PL	EASE FILL IN ALL BLANKS			
Child(ren)'s Name:					
Enrollment Date:					
Parent or Guardian's	Home Address and Employme	ent Address:			
FATHER (or Guardian)):				
Name:		Employer:			
Address:		Address:			
City:	Phone:	City:	Phone:		
MOTHER (or Guardian	າ):				
Name:		Employer:			
Address:		Address:			
City:	Phone:	City:	Phone:		
Person(s) to Whom the	he Child(ren) may be Released	by the Caregiver: (If no one, plea	se write "none")		
Name:		Name:			
Address:		Address:			
City:	Phone:	City:	Phone:		
Person(s) Who Will T Reached: (ONE NAMI		ld(ren) in an Emergency When t	he Parent (or Guardian) Cannot be		
Name:		Name:			
Address:		Address:			
City:	Phone:	City:	Phone:		
Consent to Contact F	Physician in Emergency:				
In the event I cannot b	e reached to make arrangements	s, I hereby give my consent to			
to contact Doctor					
			Name of Physician		
Phone and, if necessary, take	my child(ren) to the following do	Address ctor(s), clinics, or hospital	City		
	Signature of Parent/Guardian		 Date		





Transportation Per	rmission								
I hereby give					perm	ission to transport or			
arrange for transpor	Name of Facility ange for transportation of my child								
I understand staff wil vehicle is in motion.	I insure that my child(re	n) is placed in the app	ropriate sa	Name of Chile Ifety restraint		ka law at all times the			
Signature of Parent/Guardian						Date			
Medication Compe	etency Statement								
I,Parent /Guardian Name						have determined			
competent to give or apply medication to my child(re									
Signature of Parent/Guardian						Date			
CHILD'S MEDICAL INFORMATION									
Any health problems	s which caregiver shou	ıld know:							
-									
	Glasses, Hearing Aid,								
Any activities child(ren) should NOT enga	ge in:							
	health and/or acciden								
Certificate of Immunizations Month and Year of Each Dose									
DTaP 1	IPV 1	HIB 1	MMR 1		HEP B 1	VZV 1			
DTaP 2		HIB 2			HEP B 2	VZV 2			
DTaP 3		HIB 3			HEP B 3				
 DTaP 3		HIB 4							
DTaP 5									
DTaP – Includes	DtaP and DTP (Diphtheria, Tetanus, Pertussis) DT (Diphtheria, Tetanus–Pediatric) Td (Tetanus, Diphtheria–Adult) OPV (Oral Polio Vaccine) HIB – Haemophilus Influenzae Type B MMR – Measles, Mumps, Rubella Hep B – Hepatitis B VZV – Varicella IPV (Injectable Polio Vaccine)								
I certify that the above information is correct to the best of my knowledge.									

Date

Signature of Parent/Guardian or Physician